

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

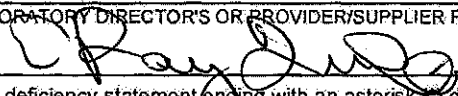
PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/13/2012
NAME OF PROVIDER OR SUPPLIER COURTLAND MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 889 SOUTH LITTLE CREEK ROAD DOVER, DE 19901		
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F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from February 7, 2012 through February 13, 2012. The deficiencies contained in this report are based on observation, interviews, review of clients' records and review of other facility documentation as indicated. The facility census the first day of the survey was (61) sixty one. The survey sample totaled twenty-six (26) residents.	F 000			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations in the resident rooms on 02/07/12, 02/09/12, and 02/10/12, it was determined that the facility failed to maintain a sanitary interior. Findings include: 1. A bed pan was observed on the floor behind the toilet of room #317. This pan was not in a bag or labeled. 2. Three (3) wash basins were left on the floor of room #313 under the sink. These basins were not bagged. 3. An input / output, measuring container was upside down on the floor next to the toilet in room #307. This container was not in a bag and not labeled.	F 253	Bed Pans, wash basins and urinals have been cleaned, labeled and appropriately stored. If unidentifiable or a single use item it will be destroyed. Resident rooms were checked and no other Residents rooms were found affected. Staff will be in-serviced on the proper labeling, cleaning and storage of these items. Residents rooms will be checked for proper labeling and storage of items by Housekeeping Supervisor on an ongoing basis.	03/30/12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

 ADMINISTRATOR 3/7/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 253	Continued From page 1 4. Two unlabeled and unbagged urinals were observed in the toilet room adjoining room #s 201 and 203 on 2/9/12 at approximately 2:30 PM. In an interview with E6 (Registered Nurse/Staff Educator) immediately after this observation on 2/9/12 confirmed that the urinals must be labeled with the resident's name and bagged when not in use.	F 253			
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R36) out of 26 sampled residents the facility failed to identify the need to conduct a significant change MDS for a resident with a newly developed pressure ulcer. Findings include: Cross refer F314 example #1.	F 274	Resident has expired so correct action cannot be accomplished. Residents were reviewed and no other residents were noted to be affected, nor were any additional incidents cited during survey. The ADON and RNAC were in-serviced on the need to assure that significant change MDS's are initiated in a timely manner per existing QA process of MDS review. The ADON will assess for status changes in Residents and confer with RNAC for needed significant change MDS. The ADON and RNAC will report to the DON per existing MDS review process.		02/20/12

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F 274	Continued From page 2 R36 was admitted on 9/12/11. The initial Minimum Data Set Assessment (MDS) dated 9/22/11 and quarterly dated 10/28/11 indicated no pressure ulcers. Record review revealed that on 11/1/11 R36 developed a stage 2 pressure ulcer that increased in size and was unstageable on 11/9/11. The pressure sore continued through November and December 2011. There was no significant change MDS initiated. Interviews on 2/10 and 2/13/12 with RNAC E6 revealed that a significant change MDS should have been done when the resident developed a significant pressure ulcer.	F 274			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	Resident 36 had expired so correction cannot be completed. Resident 12 care plan will be modified to read medicate/treat as ordered. Need for care plan revisions were reviewed and Dietary Care plans were revised to read "supplement as ordered" see MAR/TAR As the supplements are physician ordered and nurse administered the nurse must verify the order and document on the MAR/TAR upon each provision of that order. There is no need to have the specific order on the care plan. In this way potential "deficient practice" is eliminated. The Resident status report is checked by DON and ADON and any status change requiring care plan revisions are conveyed to the RNAC and followed up by the ADON.		03/31/12

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F 280	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R36 and R12) out of 26 sampled residents the facility failed to revise the care plan when care needs changed. Findings include:</p> <p>1a. Cross refer F314 example #1.</p> <p>R36 had a care plan for Prevention of Pressure Ulcers opened on 9/16/11 with a goal of skin will remain intact. Approaches included; check skin q 2 hours and report any signs of breakdown or redness to charge nurse and turn and reposition q 2 hours. The resident developed a stage 2 pressure ulcer on 11/1/11 with a care plan revision.</p> <p>Between 11/9/11 and 11/25/11 the resident's wound worsened to unstageable and multiple interventions for care and treatment were initiated including positioning changes from side to side only, a period of bed rest and nutritional interventions including protein, vitamins and a nutritional supplement drink.</p> <p>The care plan was not revised to include these interventions.</p> <p>b. A dietary care plan was initiated on 10/31/11 when the resident's weight decreased to 88.5 from an admission weight of 91. The resident was care planned as consuming at least 75% and having a normal BMI (body mass index) of 18.8.</p>	F 280	DON will check with ADON for compliance of the care plan revisions.		

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F 280	Continued From page 4 The resident was noted to be on a regular diet with no supplements. On 11/18/11 R36 was started on Vitamin C, Zinc and Protein. On 11/25/11 the protein was increased and a nutritional drink was ordered. There were no updates made to the care plan approaches and goals. c. R36 also had a care plan opened on 9/16/11 for Alteration in Urinary Elimination related to cognitive deficit and incontinence. A reassessment was made on 11/1/11 that documented no signs and symptoms of urinary tract infection. The resident had a foley catheter inserted on 12/21/11 for wound healing that was not included in the care plan. 2. Cross refer F325. R12 had an order to increase 2 cal nutritional supplement 120 ounces from two times a day to three times a day on 1/9/12. Review of the Nutritional care plan failed to include this intervention. An interview with E5 (Staff Licensed Practical Nurse) on 2/13/12 at approximately 11 AM confirmed the finding.	F 280			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	The Resident was not affected as medication was given as ordered and was effective. This is an issue of a document not a care issue. We do not create documents for the record for survey purposes. Pain management orders have been reviewed and no other Residents were affected.		03/07/12

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F 309	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review, staff interviews, and policy review, it was determined that the facility failed to provide a pain management program that met professional standards of quality for one (R49) out of 26 sampled residents. Findings include:</p> <p>R49 was admitted to the facility on 7/19/11 with diagnoses including hypothyroidism, hypertension, depression, and insomnia.</p> <p>Admission Minimum Data Set (MDS) assessment dated 7/29/11 documented that R49 had no cognitive impairment, was not on a scheduled pain medication regime and received PRN pain medication within the past 5 days. Care Area Assessment (CAA) Summary noted that a care plan was implemented for pain.</p> <p>A care plan dated 7/20/11 for alteration in comfort related to discomfort documented goals including that R49 would verbalize a decrease in pain. Approaches included:</p> <ul style="list-style-type: none"> - Assess pain level per pain flow sheet - Monitor effectiveness of pain medication - Use pain rating scale 0-10 so resident can describe pain <p>Review of the facility's policy titled "Pain Assessment and Management Procedures" documented that the purpose was to allow the residents to be as pain free as their medical condition treatment regime allows. The "Procedures, Section I" indicated that the "Assessment (Pain Assessment)" for pain were normally to be done upon: "C. Resident</p>	F 309	<p>Staff will be in-serviced on the need for pain flow sheets to be initiated on every resident order requiring pain medication, in accordance with the American Geriatrics Society Regulation.</p> <p>The ADON will review all pain management orders and monitor that the pain management protocols have been implemented. The DON will monitor the ADON as follow up.</p>		

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F 309	<p>Continued From page 6</p> <p>Complaint-when a resident complains of new pain (judgement should be used as to when last full assessment was done, current treatments, etc.)." In addition, "If the assessment form shows the presence of pain, then the flow sheet attached should be initiated to track the pain relief (management) process." Section II titled "Flow Sheets" indicated that this tool would be utilized "...To monitor new pain medications X (for) 72 hr. (hours)."</p> <p>The following pain management standards were approved by the American Geriatrics Society in April 2002 which included:</p> <ul style="list-style-type: none"> - appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. <p>Nurse's Note (N.N.) dated 1/4/12 and timed 2:30 PM documented that R49 offered complaints of soreness of right side and back and "pain assessment done."</p> <p>Review of the "Pain Assessment" dated 1/4/12 revealed that R49 was experiencing a new onset of pain on the right side and the back and rated the pain as "4" or moderate pain. R49's acceptable pain level was "2" or minimum pain.</p> <p>The subsequent N.N. dated 1/4/12 and timed at 5 PM documented an order was received to initiate Ibuprofen (non steroidal pain medication) 400 mg. (milligram) by mouth every eight hours</p>	F 309			

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F 309	<p>Continued From page 7</p> <p>around the clock with food for three days for lower back pain.</p> <p>Review of the January 2012 Medication Administration Record documented that R49 was administered Ibuprofen as ordered for total of nine administrations beginning at 5 PM on 1/4/12 and the last administration on 1/7/12 at 9 AM.</p> <p>Although the facility's policy indicated that they would utilize the Pain Flowsheet to monitor the effectiveness of the new routine pain medication regime, there was no documentation on this form. Review of the N.N. from 1/4/12 through 1/7/12 lacked evidence of a pain assessment prior to and post administration of the Ibuprofen.</p> <p>An interview with E12 (Licensed Practical Nurse) on 2/9/12 at 3 PM revealed that she documents PRN (as needed) pain medications on the Pain Flowsheet but not the routine pain medications.</p> <p>An interview with E13 (Registered Nurse Supervisor) on 2/9/12 at approximately 3:10 PM revealed that it was her understanding that new medications for pain needed to be documented on the Pain Flowsheet using a numerical scale to assess intensity of pain.</p> <p>An interview with E6 (Registered Nurse Staff Educator) on 2/9/12 at approximately 1:30 PM revealed that for new routine medications for new complaints of pain, the expectation would be that the facility utilize the standardized numerical pain scale to assess pain prior to and post administration of pain medication.</p> <p>On 2/13/12 at approximately 11 AM, the surveyor</p>	F 309			

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F 309	Continued From page 8 interviewed E4 (Assistant Director of Nursing) to determine the reason that the standardized numerical pain scale would not be utilized for the use of the Ibuprofen, however, no information was provided during the survey. The facility failed to assure that the pain management protocol for R49 met the professional standards of clinical practice as defined by American Geriatrics Society and their own facility policy. In particular, this facility failed to record a pain assessment in a way that facilitated regular reassessment and follow-up in a timely manner utilizing the same quantitative pain assessment tool used for the initial assessment. Findings were reviewed with E1 (Administrator), E2 (Assistant Administrator), and E3 (Director of Nursing) on 2/13/12 at approximately 2 PM	F 309			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R36) out of 26 sampled	F 314	Resident expired this is a closed record review which cannot be corrected. Residents have been reviewed for need of nutritional supplements to promote wound healing and no other Residents were affected. The wound care nurse will assess Residents beginning with stage 2 with pressure wounds and will automatically request a dietary consult for nutritional recommendations in accordance with the regulation. The Administration and DON will review for the presence of Stage 2 pressure		03/30/12

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F 314	<p>Continued From page 9</p> <p>residents the facility failed to initiate nutritional interventions to promote wound healing for a resident with a pressure ulcer. R36 developed a pressure ulcer at the facility. The facility failed to have nutritional supplements in place until three weeks after R36 developed the wound. Findings include:</p> <p>1. R36 was admitted on 9/12/11 from an assisted living facility with diagnoses which included Alzheimer's dementia, congestive heart failure, peripheral neuropathy, hyperlipidemia, hypertension and hypercholesteremia.</p> <p>The initial Minimum Data Set Assessment (MDS) dated 9/22/11 and quarterly MDS dated 10/28/11 indicated the resident was dependent with all activities of daily living except eating.</p> <p>R36 was assessed 9/12/11 with a score of 13 and 11/3/11 scored 14 indicating a moderate pressure sore risk based on the Braden scale.</p> <p>A care plan for Prevention of Pressure Ulcers was opened on 9/16/11 with a goal of "skin will remain intact". Approaches included; "check skin q 2 hours and report any signs of breakdown or redness to charge nurse and turn and reposition q 2 hours". Incontinence care was also addressed in the resident's care plan.</p> <p>An interview on 2/10/12 at 2:10 PM with E8 RN and E9 RN revealed R36 was in a geri-chair with a cushion and had a pressure reducing mattress on the bed.</p> <p>A dietary assessment was completed on 9/19/11 and reviewed again on 10/31/11 with no needed</p>	F 314	wounds and follow up that a dietary consult was initiated.		

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F 314	<p>Continued From page 10</p> <p>interventions due to good food and fluid intake. Review of facility documentation revealed the resident was eating 75% to 100% of her meals.</p> <p>A nurse's note dated 11/1/11 and timed at 10 PM revealed a Stage 2 bed sore was noted on sacrum during care. The facility's standing treatment orders were initiated. On 11/2/11 the record revealed the treatment was changed to Tegaserb to be changed every 3 days and as needed.</p> <p>The wound assessment documentation for 11/2/11 described a 2 cm by 3 cm open area to left upper buttock with red granular tissue. The physician assessed the resident on 11/3/11 with no new orders. On 11/4/11 the measurements were 1.2 cm by 1.2 cm red with granulation. The wound sheet indicated the resident was on a low air loss mattress.</p> <p>An interview on 2/10/12 at 2:10 PM with E8 RN revealed that when he changed the Tegaserb on 11/5/11 the wound was still a stage 2 and looked good and looked fine again on 11/8/11 during the day shift. E8 revealed that on 11/9/11 the wound change was noted and the treatment changed.</p> <p>On 11/9/11 at 3 PM a nurse noted an unstageable ulcer to sacral left buttock area (resident's doctor E10) was called and aware. The treatment was changed to Hydrogel (slow debridement treatment) and the resident was ordered to stay in bed except during meals and turn side to side only. The wound sheet for 11/9/11 described the wound as 3 cm by 3 cm by 1.4 cm, black in color, necrotic tissue and unable to determine stage.</p>	F 314			

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F 314	<p>Continued From page 11</p> <p>There was however no orders for vitamin, mineral or protein supplements to aid in healing until 11/18/11, three weeks after the resident acquired the wound. On 11/18/11 an order was obtained for a dietary consult and bed rest for 72 hours as tolerated. On the same date an order for Promod (protein) powder one scoop twice a day, Zinc 220 mg daily, Vitamin C 500 mg daily, pre-albumin, albumin, and complete metabolic profile on next lab day was obtained.</p> <p>On 11/18/11, the wound was described as 4.5 cm by 4 cm by 1.6 cm, yellow/black/tan in color and with necrotic and slough tissue.</p> <p>The labs competed on 11/22/11 indicated a very low pre albumin of <7.0 (18-38 mg/dl), albumin 2.3 low (3.2-5.0 mg/dl), total protein 5.9 low (6.0-8.3 g/dl).</p> <p>On 11/25/11, a physician's order was obtained on recommendation of the dietitian for protein increased to 2 scoops twice a day (bid) for wound healing and a 2 cal supplement 4 oz at bedtime (hs). The wound treatment was changed to Santyl for debridement of the affected tissue.</p> <p>On 11/25/11, the wound was described as 5 cm by 4 cm by 2.3 cm, red and yellow in color with granulation and slough tissue. This was the largest measurement documented. The wound between 11/30/11 and 1/6/12 improved in appearance with a 1/6/12 description of 3.2 cm by 3.2 cm by 1.2 cm with granulation tissue.</p> <p>An interview with the E7 dietitian (RD) on 2/13/12 at 11 AM revealed that the facility wrote the</p>	F 314			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2012
FORM APPROVED
OMB NO. 0938-0391

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F 314	Continued From page 12 nutritional referral on 11/18/11 and she was unaware of the skin breakdown until then. She stated the facility had already ordered the supplements they thought were necessary on 11/18/11. She reviewed the resident on 11/21/11 and made some clarification orders that included increasing the protein to BID, adding 2 cal hs and ordering the supplements only till wound healed. She stated she went down and talked to the resident and let her sample the 2 cal. R36 did not like it but agreed to try it in the evening and told E7 that she did not want to gain weight using supplements. E7 revealed that the resident needed 50 g of protein a day on admission. Her consumption of 75% plus of meals was providing her with 65 g. of protein daily. E7 added the protein powder and evening supplement to increase the protein for wound healing. An interview on 1/13/12 with the DON E3 and ADON E4 confirmed that a nutritional referral was not made when R36 acquired a pressure sore in the facility. E4 who is also the wound nurse for the facility revealed that due to the resident's good food and fluid intake she did not consider the dietary referral until after she had tried other approaches to heal the wound. She further revealed that the wound continued to heal despite the resident's failing health and subsequent death on 1/7/12.	F 314			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels,	F 325	By the time of survey, the issue had been corrected and Resident was receiving the supplement as recommended. In investigating how the incident occurred it was determined that the note	03/30/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 325	<p>Continued From page 13</p> <p>unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview it was determined that the facility failed to ensure one (R12) out of 26 sampled residents maintained acceptable parameters of nutrition in the area of weight and supplement consumption. Findings include:</p> <p>R12 was admitted to the facility on 4/14/11 with diagnoses including organic brain syndrome, chronic kidney disease-stage 5, hypertension, dementia, insulin dependant diabetes mellitus, poor vision, and was on hemodialysis.</p> <p>On 12/14/11, R12 was readmitted to the facility from the hospital after treatment for metabolic encephalopathy secondary to hypoglycemia. R12 had diagnoses including organic brain syndrome, chronic kidney disease-stage 5, hypertension, dementia, insulin dependant diabetes mellitus, poor vision, and was on hemodialysis.</p> <p>Review of E7's (Registered Dietitian/RD) tracking document noted the admission weight on 4/14/11 was of 179.5# and edema was noted and R12's height was 61 inches. The monthly weight for December 2011 was documented as 178#.</p> <p>R12's care plan titled "Nutrition, risk potential</p>	F 325	<p>to the MD and dialysis was done outside normal facility channels possibly resulting in facility not monitoring for or receiving the order timely. No other situation of going outside facility procedure was identified.</p> <p>The Dietician will be in-serviced to make sure the ADON and DON are given the recommendation so it is distributed within the tracking system of the facility.</p> <p>Will be monitored by the Administration Staff.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 325	<p>Continued From page 14</p> <p>related to therapeutic diet and body mass index greater than 24" implemented on 4/18/11 included the following goals for R12:</p> <ul style="list-style-type: none"> - Maintain weight or lose 1 to 2 # (pounds) a month. - Will consume > 75% of meals. <p>Approaches included:</p> <ul style="list-style-type: none"> - Provide preferred foods as much as possible. - Monitor intake of meals 3 X a day X 90 days - Weigh resident monthly or per facility procedure and record - Two Cal 4 oz. (ounces) 2 X per day - Prosource three scoops 2 X per day <p>On 12/6/11, R12 was admitted to the hospital due to worsening mental status and hypoglycemia. Review of the hospital discharge summary dated 12/14/11 included a primary diagnoses of (1) metabolic encephalopathy secondary to hypoglycemia (2) paroxysmal atrial fibrillation (3) peripheral vascular disease with gangrene of right fifth metatarsal, right fifth toe. On 12/14/11, R12 was readmitted to the facility.</p> <p>Review of E7 (Registered Dietitian/RD) "Consulting Dietitian's Report" dated 12/19/11 to the attention of R12's attending physician and the dialysis center documented that R12's meal intake average was 25% with staff assistance at meal time. E7 recommended and requested an order for "2 Cal 4 ounces" be increased from two times a day to three times a day. This documentation included the handwritten initials of the E14 (Nurse Practitioner) and date of 1/2/12 (approximately 14 days after) acknowledging and agreeing with E7's recommendation.</p> <p>R12's January 2012 monthly physician's order</p>	F 325			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 325	Continued From page 15 sheet documented that R12 was on a renal no concentrated sweet diet with 1200 cc fluid restriction. Additionally, R12 was ordered "Two Cal" nutritional supplement 4 oz. 2 X (times) per day and "Prosource" (high protein supplement) three scoops 2 X per day. On 1/9/12 (approximately seven days after), a physician order was written for "2 Cal supplement 4 oz (ounces) TID (three times a day) and to record mls (milliliters) intake on the MAR (Medication Administration Record). Review of the post dialysis weight on 1/3/12 was 162.1# indicating approximately a 16# or 9% weight loss. An interview with E7 on 2/13/12 at approximately 1 PM revealed that she had to check on the status of the above recommendation twice and recalled that after the second inquiry, the recommendation was agreed upon to increase the supplement to TID on 1/2/12, approximately 21 days after the initial recommendation on 12/19/11. Although R12's meal consumption decreased and E7 recommended change in the intervention to increase the 2 Cal supplement, the facility's system failed to ensure a timely implementation of the order.	F 325			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371	The issues cited included holding food at 45 degrees F in to Medication/Nourishment Refrigerators. "Medication" temps are maintained. The surveyor cited 44 degrees F as being "recorded". Reference to the Food Code		03/30/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	<p>Continued From page 16</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview it was determined that the facility failed to handle food in a sanitary manner and failed to maintain resident snacks at a temperature to prevent the potential for food-borne illness. Findings include:</p> <p>1. During a lunch observation on 2/7/12 at 12:25 PM aide E15 was observed preparing and feeding R52 bread with her bare hand. E15 was sitting between R52 and R16 helping them both with their meals resulting in her touching the bread with her bare hands multiple times.</p> <p>2. During a lunch observation on 2/13/12 at 12:10 PM aide E15 was feeding R16 and R52. E15 used her bare hands to open and feed R52 his roll. She then returned to feeding R16.</p> <p>3. The internal thermometer temperature of the Haier-brand refrigerator on the C wing was 44 degrees Fahrenheit (F). Resident snacks were stored in the refrigerator. The monitoring log for the month of February showed several readings above 41 degrees F.</p> <p>4. The internal thermometer temperature of the Haier-brand refrigerator on the D wing was 43</p>	F 371	<p>Section 3-501.18 clearly indicates that 41 degrees F and 45 degrees F or below are acceptable as long as the "shelf life" is reduced from 7 to 4 days. There is compliance with this requirement so corrective action is unnecessary.</p> <p>A second issue was noted where a single employee used his/her bare hands to give bread to a Resident.</p> <p>We have not observed other employees bare handling food stuffs while feeding patients. Dietary Staff complete serve safe training and certification as part of their training.</p> <p>CNA staff will be in-serviced regarding the need to feed resident via utensil or glove/ protected hands.</p> <p>The Nurse Supervisor and Food Service Supervisor will monitor CNA staff at meals.</p> <p>The Food Service Supervisor will report to the ADON/DON via the daily stand-up meeting or Supervisors report any violations of food protection regulation.</p>		

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F 371	Continued From page 17 degrees Fahrenheit (F). Resident snacks were stored in the refrigerator. The monitoring log for the month of February showed several readings above 41 degrees F. Interview on 02/13/12 with E3, D.O.N., indicated that the temperature range on the monitoring log reflected medication parameters and did not include the upper limit for cold food temperature.	F 371			
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520	This citation indicates that the absence of one of the required committee members is a violation of regulation. We understand that the DON, Medical Director, and three other staff members (5 total people) must be present. As all permanent members of the CMI QA committee are aware of the meeting date and time but may not be present for any given reason CMI will postpone any meeting where the DON is absent, where the Medical Director is absent or where less than 5 members total are present. While this may result in missing the "Quarterly" day count we understand that the presence of the DON and Medical Director supersede other considerations, while the four points of a POC do not seem to apply we submit the following: The facility administrator will call the physician to remind him of the meeting one week prior to the meeting. Other key staff will be reminded to attend the meeting during the week prior to the meeting. The Administrator will keep a reminder log, initiated by in house staff of notice	03/30/12	

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F 520	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on interview and review of facility records it was determined that the Medical Director or designee failed to attend one out of three quarterly meetings. Findings include: Review of the quarterly quality assurance meeting sign-in sheets with the Administrator (E1) revealed that the Medical Director attended the 7/29 and 10/28/11 meeting but failed to attend the 1/20/12 quarterly meeting. E1 stated when asked the Medical Director, (E11) forgot about the meeting.	F 520	and re-notice. The Quality Assurance Committee will monitor the compliance with the reminder.		


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STATE SURVEY REPORT

Page 1 of 4

NAME OF FACILITY: Courtland ManorDATE SURVEY COMPLETED: February 13, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>An unannounced annual survey was conducted at this facility from February 7, 2012 through February 13, 2012. The deficiencies contained in this report are based on observation, interviews, review of clients' records and review of other facility documentation as indicated. The facility census the first day of the survey was sixty-one (61). The survey sample totaled twenty-six (26) clients.</p>	
3201	<p>Skilled and Intermediate Care Nursing Facilities</p>	
3201.1	<p>Scope</p>	
3201.2	<p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to the CMS 2567-L survey report dated 2/13/12, F253, F274, F280, F309, F314, F325, F371, F520.</p> <p>§483.25 Quality of Care</p> <p>Each resident must receive and the facility must provide the necessary care</p>	<p>Cross refer Federal Survey Response to the CMS 2567 -L survey report dated 2/13/12, F253, F274, F280, F309, F314, F325, F371, F520.</p> <p><i>Corrections by 3/30/12</i></p>

[Signature]
3/14/12


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STATE SURVEY REPORT

Page 2 of 4

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	<p>and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on interview, record review and review of facility's policy, it was determined that the facility failed to address the physical need of one (S2) out of two sub-sampled residents, who experienced itching for 7 days while being treated for scabies and did not receive medical treatment until another complication presented itself. Findings include:</p> <p>S2 was admitted to the facility on 5/9/11 with diagnoses including Alzheimer's disease, senile dementia, osteoporosis, hyperlipidemia and hypertension. Nursing admission assessment dated 5/9/11 documents pitting edema of both legs but no skin anomalies. The recertification/progress note dated 1/2/12 documented the resident's skin as "intact and normal turgor".</p> <p>S2's nurse's note dated 1/12/12 at 2:40 PM documented "NP (nurse practitioner) notified of rash to body- states her or MD (physician) will be in to look at it". On 1/13/12 the progress note by E14.NP. described the rash on S2's arms, legs, back waist line and lower abdomen and documented under assessment "prob.(probably) Scabies with superimposed bacterial infection on arms." An order for Elimite 5% (ointment prescribed for scabies treatment): shower patient, apply cream from neck to feet—wait 10-12 hours—shower again and</p>	


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STATE SURVEY REPORT

Page 3 of 4

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	<p>Keflex (an antibiotic) 500 mg (milligrams) p.o. (oral) BID (twice daily) times 7 days was written at 2 PM 1/13/12 for S2.</p> <p>The nurses' notes dated 1/15/12 documented at 2:30 PM that S2 was scratching all shift and a small fluid filled blister was noted on the right shoulder. At 9 PM it was documented that S2 was constantly scratching arms and they had to be wrapped in kling (gauze) to prevent scratching. Nurses' notes continued to document S2 scratching on 1/16/12, 1/17/12, 1/18/12 and 1/19/12 on the day and/or evening shifts.</p> <p>On 1/16/12 the physician wrote an order for Elimate 5% application at bedtime on 1/20/12 and shower off in AM 1/21/12 (12 hour period) and to discontinue Isolation precautions. On 1/22/12 the nurses' notes on day shift (time missing) and 10 PM documented S2 "itching continues or scratching behaviors".</p> <p>The nurse's note dated 1/23/12 documented, at approximately 11:45 AM, the rash was on the chest, abdomen, back, arms and legs but the increased scratching caused the skin to open and the severe itching was causing distress; the NP (E14) was notified and instructions for "Benadryl (antihistamine) 25 mg po now then repeat at 6 PM then as needed every 8 hours" and "do not apply topical creams/ointments at this time". Also documented was "she (the NP) will be in later today to further assess. Benadryl 25 mg po given at 11:30". The nurse's note at 2:45 PM documented "N.P. in to assess N.O. (order) Atarax 25mg po q 8 hrs x (times) 5 days then 8 hrs (hours) prn (as needed for) itching-hold for sedation. The nurse's note on 1/24/12 documented</p>	


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STATE SURVEY REPORT

Page 4 of 4

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	<p>"no scratching noted this shift".</p> <p>An interview with E12, unit nurse on 2/13/12 at 10:30 AM concerning S2's notes of itching and scratching, revealed verbal nursing efforts to make the physician and or nurse practitioner aware of the situation between January 13- 23, 2012 but could not recall the dates. E13, acting supervisor was also present and recalled a physician and or nurse practitioner being on the unit during that time period but there was no progress note for the dates 1/16/12, 1/23/12 or 1/24/12. Both nurses confirmed the medication administration (MAR) and treatment records for January 2012 noting Eucerin Lotion to dry skin daily and prn as well as Tylenol 325mg 2 tablets every 4 hours as needed for mild pain were the only treatment ordered until 1/23/12. There was no documentation that any physician and or nurse practitioner was notified of the increased itching or continuous scratching by the nursing staff until 1/23/12.</p> <p>On 2/13/12 the medication administration record and nurses notes for January 2012 were reviewed with E3, DON. She was not aware that S2's physician and or nurse practitioner did not prescribe any medication for her itching discomfort until 1/23/12 when she was receiving treatment for scabies and there were complaints of itching and scratching.</p>	